MARYLAND PHARMACIST VOLUNTEER CORPS (MPVC) FORM

Please print or type. Fax completed form to **410.358.9512.**

_____ **Yes, I would be willing to volunteer my time to distribute and/or dispense prescription drugs in an emergency situation.**

Last Name	**First Name**	**M.I.**

License #	**Expiration Date**

Please Check One: [ ] Pharmacist [ ] Pharmacy Technician

Mobile Phone #	**Pager #**

In the event of an actual emergency, I can be best reached by (Specify One Phone # or E-mail Address)

Daytime	**Nighttime**

Counties where I would volunteer

[ ] I am willing to serve in any area of the state (Check here)

WORK INFORMATION

Employer Name / Store #	**Permit #**

Work Address: Number Street

City	**State**	**Zip Code**	**County**

Work Phone #	**Fax # (Business)**

E-Mail (Business)	**Normal Work Hours**

HOME INFORMATION

Home Address: Number Street Apt. #

City	**State**	**Zip Code**	**County**

Home Phone #	**Fax # (Home)**

E-Mail (Home)	**Hours When I May be Contacted at Home**

Specialized Training/Certification in (Check all that apply): [ ]Anthrax [ ]Smallpox [ ]Plague [ ]Tularemia

Spoken Language(s)	**Sign Language**

Maryland Board of Pharmacy
4201 Patterson Avenue
Baltimore, MD 21215-2299
Phone: 410.764.4755

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

PHARMACIST VOLUNTEER CORPS AUTHORIZATION FORM

Pursuant to the Annotated Code of Maryland, State Government Article, § 12-101(a)(3)(ii) and the Code of Maryland Regulations 25.02.01.02B(8), the Maryland Department of Health and Mental Hygiene hereby recognizes _____, (the "Volunteer") , as a volunteer who may perform any duties authorized by the Governor, the Secretary of the Department of Health and Mental Hygiene, the Board, or their agents. When performing duties so authorized, the Volunteer qualifies as State personnel under the Maryland Tort Claims Act, Annotated Code of Maryland, State Government Article, § 12-105, and the Courts and Judicial Proceedings Article §5-522(b), meaning that the Volunteer is immune both from suit in the courts of the State and from liability for acts or omissions within the scope of the Volunteer's authorized duties that are performed without malice or gross negligence.

By signing this document, the Volunteer agrees to perform only those duties authorized by the Governor, the Secretary of the Department of Health and Mental Hygiene, the Board, or their agents, and understands that the Volunteer is immune from both suit and liability to the extent provided under the above referenced statutes. If the Volunteer wishes to obtain protection from suit or liability for acts performed that are not authorized by the Governor, the Secretary, the Board, or their agents, the Volunteer agrees and understands that it is the Volunteer's sole responsibility to obtain the necessary insurance coverage.

The Volunteer is a civil defense volunteer as defined under the Workers' Compensation Act, Annotated Code of Maryland, Labor and Employment Article, § 9-232.1(a)(2). As such, if the Volunteer is called upon by the Department to perform duties **during scheduled emergency training or during an emergency**, the Volunteer will be considered to be a civil defense volunteer under that statute and will be eligible for workers' compensation to the extent provided under the Workers' Compensation Act when volunteer services are provided during an emergency. The Volunteer understands and agrees that the Volunteer is solely responsible to obtain additional insurance to cover the Volunteer's injuries or illnesses that may not be covered by the Workers' Compensation Act.

_____ _____
Volunteer Name (Please Print) Volunteer Signature and Date

ON BEHALF OF THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, I RECOGNIZE _____ AS A VOLUNTEER AUTHORIZED TO PERFORM DUITES AS PROVIDED ABOVE.

Licensure Status_____ License/ID # _____

_____ _____
Maryland Department of Health and Mental Hygiene Date